Short Term & Long Term Strategies to Ensure the Viability of the CSHBP and the Small Group Market

Presentation to

Maryland Health Care Commission

September 15, 2005

Background Information

Origins of Small Group Reform

- Concern about escalating costs
- Concern that insurance was unavailable or not affordable for small businesses with higher risk employees
- Reform provided for:
  - Elimination of medical underwriting
  - Elimination of pre-existing condition exclusions
  - Guaranteed issue and guaranteed renewal

- Solution is, of course, a trade-off
  - Employees with medical conditions / above standard risk (roughly 20% of the population) get insurance at a lower cost with no exclusions
  - Relatively healthy employees pay more than they would otherwise – or conclude the insurance doesn't represent a good value
  - Creates the necessary conditions for a death spiral in the small group market
- Are there approaches that strengthen and protect the small group market while preserving key values reflected in modified community rating ?

Current Reassessment

- Discussion of reforms arises from concerns about the high cost of insurance in the small group market and the high number of employees of small businesses who are uninsured
- Exceeding the 10% cap is a somewhat artificial event, but triggers an explicit reevaluation of the small group market and the CSHBP

Current Benefit Design

Requirements under the Health Insurance Reform Act of 1993 (HB 1359)

- Participating insurers must offer the CSHBP to small business with 2 to 50 eligible employees
- Additional benefits may be offered to enhance the program but not diminish it; these “riders” must be priced and sold separately
- The CSHBP has a floor equal to the actuarial equivalent of the minimum benefits required to be offered by a federally qualified HMO
- The CSHBP has a ceiling: The average cost of the Plan cannot exceed 10% of Maryland’s average annual wage

Comprehensive Standard Health Benefit Plan

(Available since July 1, 1994)

Basic Tenets

- One standard benefits package (purchase based on cost and quality)
- Guaranteed Issue
- Guaranteed Renewal
- No preexisting condition limitations (no medical underwriting)
- Modified Community Rating (based only on age and geography)

Latest Facts about the CSHBP

- The average loss ratio for the CSHBP was about 81% in 2004
- The average cost per employee (without riders) was $4,335 in 2004 (slightly above the cap; projected to be slightly below the cap in 2005)
- The average cost is projected to be about 103.3% of the cap in 2006
- More than 90% of policies are sold with riders
- The average employer spends an additional $1,300 per employee per year to purchase riders, bringing the average total cost per employee to more than $5,600
- The most popular riders are riders to buy down the PPO deductible and the Rx deductible
- **More than 58% of Maryland small employers have not purchased the CSHBP**

Limited Benefit Plan (LBP)
(Available July 1, 2005)

- Benefits have the same breadth but less depth than CSHBP
- Contains the same guarantee provisions as the CSHBP
- Insurers with at least 10% of the lives insured in the small group market must offer the LBP
- LBP is available to small employers that:
  - have not provided coverage in the prior 12 months
  - have an average wage that does not exceed 75% (approximately $32,000) of the Maryland average annual wage (MAAW)
- MHCC must ensure the actuarial value of the LBP does not exceed 70% of the actuarial value of the CSHBP as of January 1, 2004

Number of Mandated Benefits Maryland v. Neighboring States

State	***Number of Maryland Mandated Benefits Required in Neighboring States***
Delaware	16
District of Columbia	11
Maryland	**40**
Pennsylvania	15
Virginia	22

Mandates Unique to Maryland

Maryland Mandate	Full Cost as a Percentage of Premium
15-801: Alzheimer's disease and care of elderly individuals	0.0%
15-810: In vitro fertilization	0.8%
15-813: Disability caused by pregnancy or childbirth	0.0%
15-819: Outpatient services and second opinions	0.0%
15-820: Prosthetic devices and orthopedic braces	0.0%
15-823: Osteoporosis prevention and treatment	0.5%
15-824: Maintenance prescription drugs	0.1%
15-829: Chlamydia screening	0.1%
15-833: Extension of benefits	0.0%
15-835: Habilitative services for children	0.0%
15-836: Hair prosthesis	0.0%
15-838: hearing aid coverage for children	0.1%
15-840: Residential crisis services	0.0%
Total	**1.6%**

Mandates Common to Neighboring States

Maryland Mandate	Full Cost as a Percentage of Premium
15-802: Mental illness; drug & alcohol	4.9%
15-803: Blood Products	0.5%
15-804: Off-label use of drugs	0.3%
15-805: Pharmaceutical products	0.1%
15-806: Choice of pharmacy	0.0%
15-807: Medical foods & modified food products	0.0%
15-808: Home health care	0.4%
15-809: Hospice care	0.0%
15-811: Hospitalization benefits for childbirth	2.1%
15-812: Length of stay for mothers of newborn	1.0%
15-814: Mammograms	0.5%
15-815: Reconstructive breast surgery	0.1%
15-816: Routine gynecological care	0.0%
15-817: Child wellness	0.7%

Mandates Common to Neighboring States (cont.)

Maryland Mandate	Full Cost as a Percentage of Premium
15-818: Treatment of cleft lip and cleft palate	0.2%
15-821: Diagnostic 7 surgical procedures, face & neck	0.3%
15-822: Diabetes equipment, supplies, & self mgt training	0.6%
15-825: Detection of prostate cancer	0.7%
15-826: Contraceptives	0.2%
15-827: Clinical trials under specific conditions	0.2%
15-828: General anesthesia for dental care	0.0%
15-830: Referrals to specialists	0.0%
15-831: Prescription drugs and devices	0.0%
15-832: Length of stay for mastectomies	0.0%
15-834: Prosthesis following mastectomy	0.0%
15-837: Colorectal cancer screening	0.1%
15-839: Treatment of morbid obesity	0.5%
Total	**13.6%**

Rejuvenating the Small Group Health Insurance Market

- The small group plan design has become increasingly unaffordable for more and more Marylanders
- Two insurers have a combined market share of about 94% of the small group market business
- The Limited Benefit Plan experiment is failing in the market place due to unrealistic parameters
- **58.8% of small employers do not participate in the small group market**

Metrics

Participating insurance carriers:

1995: 37 2004: 9

Employer participation:

1999: 58,495 2004: 50,820

Employee participation:

1998: 489,473 2004: 451,739

Impact of Constraints within the CSHBP

- Currently, insurers are restricted to use of age and geographic location of the business when establishing community rates
- These restrictions make insurance “more” affordable for unhealthy members but “less” affordable for healthy members
- Cost serves as a disincentive for younger healthy individuals to enter the small group plan
- Non-participation by young healthy employees puts additional upward pressure on the community rate

Goal of Small Group Reform

To transition the CSHBP from a highly prescriptive to a more permissive plan design, thereby providing:

- Greater choice for employers and employees in benefits and cost
- Flexibility for insurers in benefit design and price
- Increased employer participation
- Increased participation by young and healthy individuals

Potential Short Term Reform Options

Potential Option for Reform

Option I: Modify the existing CSHBP as follows:

Projected Ratio of Premium Rate to the Cap by 2006: 103.3%

Modify pharmacy benefit from:
$15/$25/$50 with a $250 per person deductible, no annual maximum to
$15/$30/$60 with a $500 per person deductible, $2,000 annual maximum

Sub-Total of Cost Reductions: - 4.7%

Projected Ratio: 98.6%

Impact of Option I

- Maintains all current CSHBP benefits
- Reduces projected cost of CSHBP below the statutory limit for 2006
- Increases the deductible and reduces the annual maximum for the pharmacy benefit

Potential Option for Reform

Option II: Modify the existing CSHBP as follows:

Projected Ratio of Premium Rate to the Cap by 2006:	**103.3%**
Transition the pharmacy benefit from the existing CSHBP	**- 9.0**
Add a Pharmacy Discount Card	**+ 0.2**
Sub-total:	***- 8.8%***
Projected Ratio:	**94.5%**

Impact of Option II

- Transitions the pharmacy benefit from the current CSHBP to rider status
- Provides a pharmacy discount card as part of the CSHBP
- Creates a market environment for increased competition among insurers
  - Greater creativity in benefit design
  - More competitive pricing
  - More participating insurers
- Allows for greater employer/employee choice

Potential Option for Reform

Option III: Modify the existing CSHBP to FQHMO minimum:

Projected Ratio of Premium Rate to the Cap by 2006: **103.3%**

Transition the following benefits from the existing CSHBP:

Pharmacy Benefit	- 9.0
Expanded Mental Health	- 2.0
Transplants	- 2.0
Durable Medical Equipment	- 1.8
Expanded Outpatient Short-Term Rehab	- 1.1
Chiropractic	- 0.4
Skilled Nursing Facility (20 days, in transition only)	- 0.4
Ambulance	- 0.3
Blood & Blood Products	- 0.5
Sub-total of Cost Reductions:	***- 17.5%***
Add a Pharmacy Discount Card	**+ 0.2**
Sub-total:	***- 17.3%***
Projected Ratio:	**86.0%**

Impact of Option III

- Modifies the current rigid prescriptive design of the CSHBP
- Significantly reduces the cost of the base CSHBP
- Provides a more price sensitive option for the 58% of small employers who do not currently participate in the CSHBP (mainly because of cost)

Impact of Option III (cont.)

- Creates a market environment for increased competition among insurers
  - Greater creativity in benefit design
  - More competitive pricing
  - More participating insurers
- Provides employers and employees with more benefit choices
- Provides employers and employees with more cost options

Long-term issues and options

Who are the uninsured in Maryland?

(MHCC's report: Health Insurance Coverage in Maryland, 2002-3)

- 740,000 individuals, including 140,000 children (13.6 % of the population)
- the majority are young – and, based on nationwide data, healthy
- 87% live in families with at least one adult worker
- 46% are single adults who are not parents
- 49% have incomes below 200% FPL ($29,620 for a family of 3)
- 29% are not US citizens
- Uninsurance rates are higher in our Hispanic (48%) and black (17%) populations
- A significant number of the uninsured are either on Medicaid/MCHIP (the "Medicaid undercount") or are eligible

Figure 4

Health Insurance Coverage of the Nonelderly by Age, 2002-2003

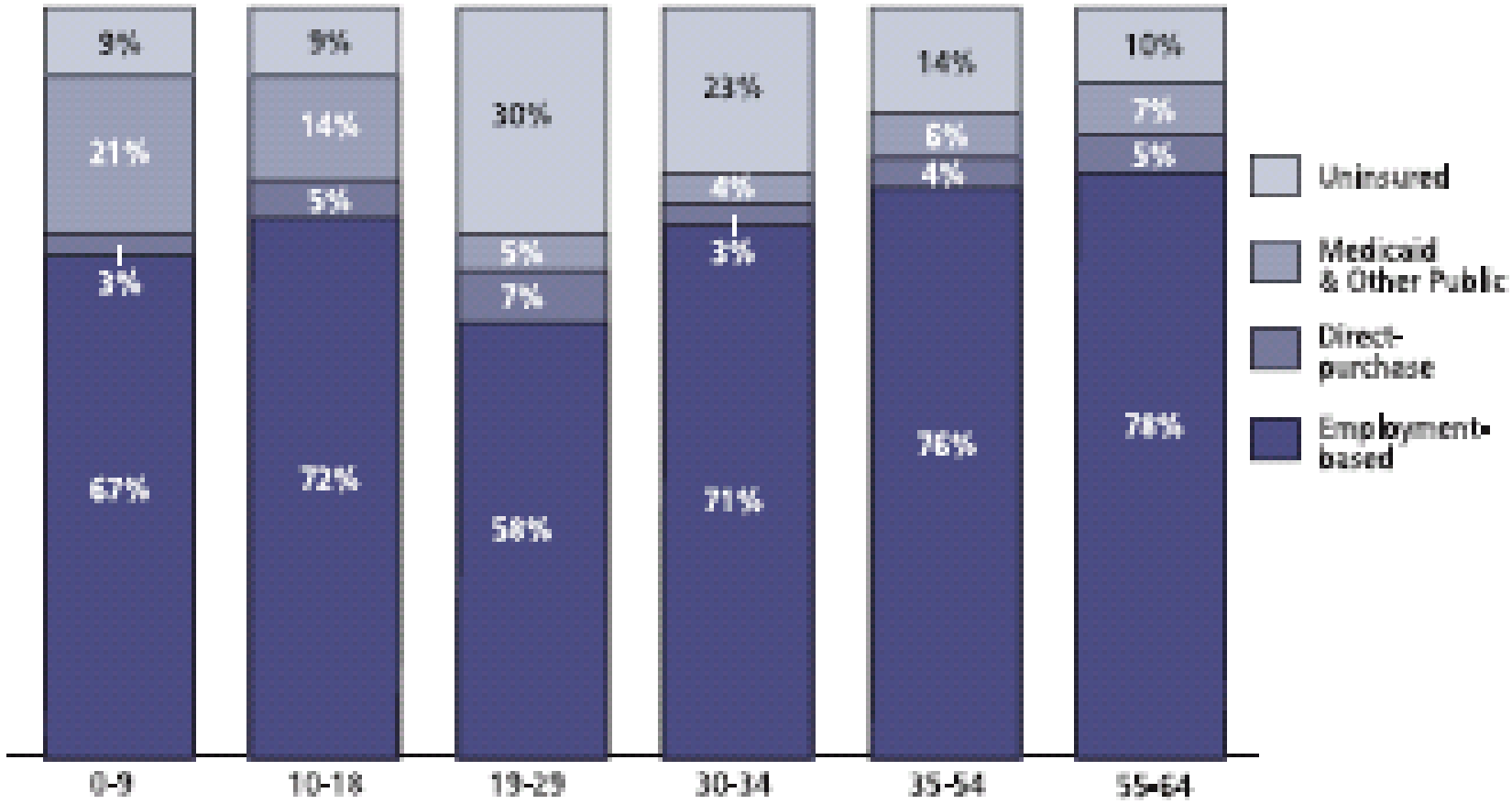
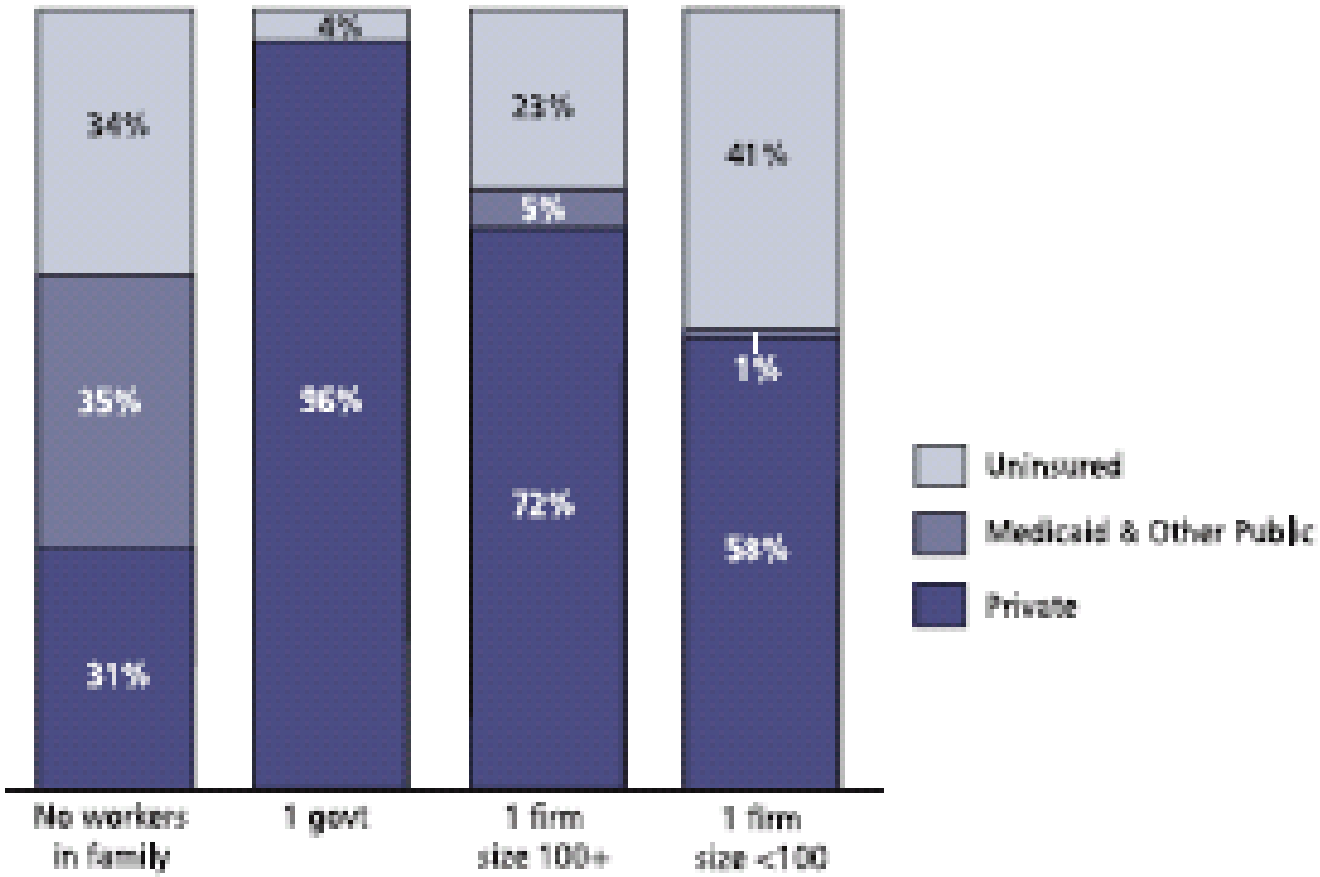


Figure 19

Health Insurance Coverage of the Nonelderly by Family Work Status: Persons Not Living with Relatives, 2002-2003



Burden of Uncompensated Care

- In Maryland, out of pocket costs to cover the uninsured will be nearly $713 million in 2005
- By 2010, out of pocket costs to cover the uninsured will be nearly $998 million

What does this mean for Marylanders?

- Health Insurance Premiums on the Rise
  - In 2005, private employer-sponsored health coverage had premiums that are **$948** higher due to the uninsured
    - Premiums for individual coverage are **$332** higher in 2005
  - By 2010, private employer-sponsored coverage will be **$1,510** higher due to the uninsured
    - Premiums for individual coverage will be **$506** higher in 2010

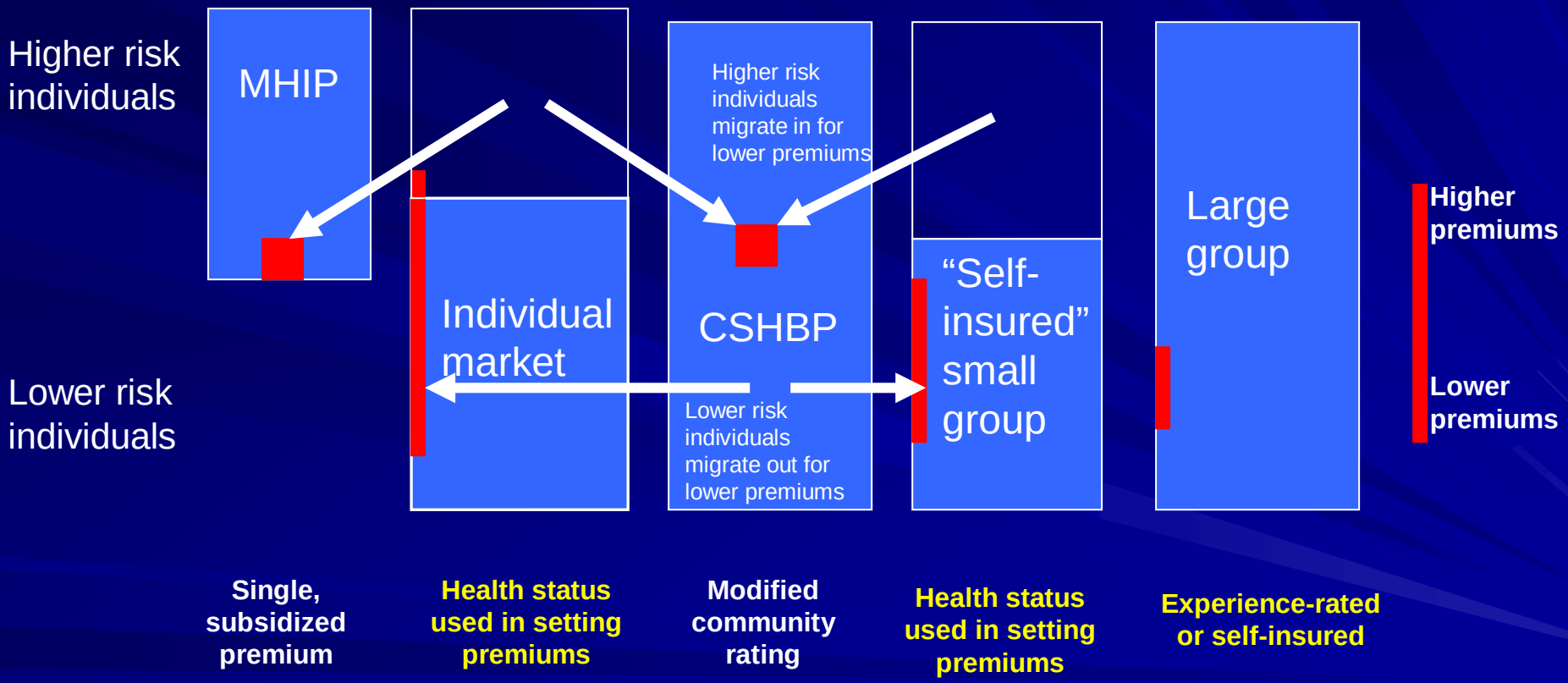
Community rating and its impact on risk

- Modified community rating reflects important community values, particularly risk pooling and a sharing of the costs of serious illnesses

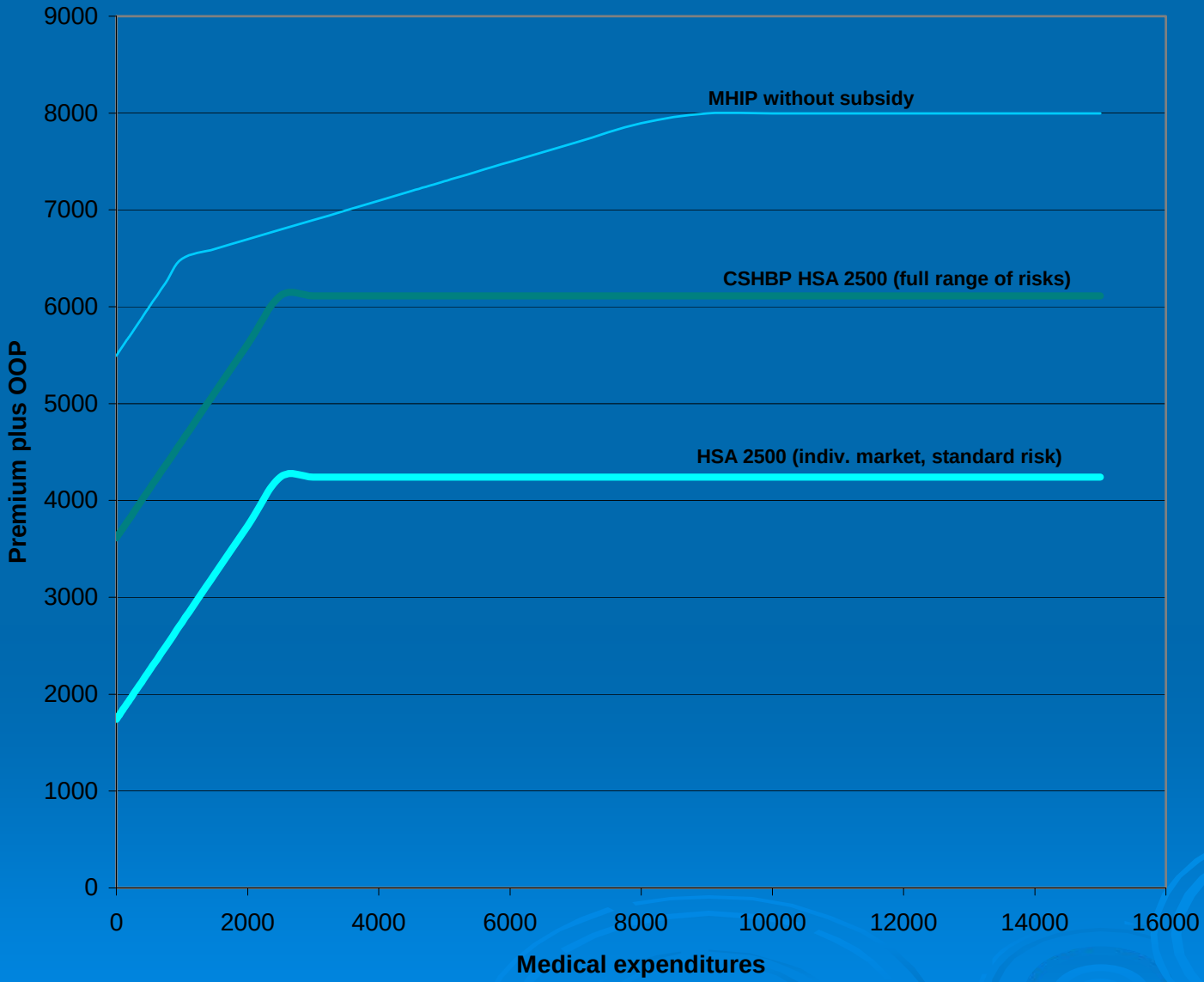
- Paradoxically (but predictably) the success of modified community rating creates significant problems with the resulting risk pool, premiums, and program viability
  - Migration of high-risk individuals into the program
  - Failure to attract low-risk individuals into the program
  - Premiums that reflect increased risk

Health, Risk, and the Marketplace

Maryland small group health insurance in context: Risks, premiums, and migration



Maryland plan comparisons showing relative risk



Note: OOP costs of MHIP and CSHBP are slightly overstated because the plans pay part of pharmacy expenditures between $250 and when the overall deductible is met.
Also, MHIP and CSHBP include limited Skilled Nursing

Boundary issues

- Protecting against adverse selection and premium death spiral
- Attracting a broader and more representative risk pool

Problem: “self-funded” plans compete with CSHBP for low risk groups

- Self-funded plans with stop-loss policies are protected from most state regulation by ERISA
  - Part of the appeal of self-funded plans is the flexibility to design the benefits, in contrast to:
    - “hard mandates” in the fully insured group and individual markets
    - “soft mandates” adopted in the CSHBP
- Impact:
  - Employers enjoy low premiums while low risk, then when illness occurs, enter the CSHBP
- Possible Strategies:
  - Limit entry into the CSHBP for any employer self-insured in the recent past
  - Allow insurers to exclude pre-existing conditions from coverage for a period of time
  - Create CSHBP premiums that remove the incentive to switch
    - Surcharges to all new entrants
    - Surcharges targeted at formerly self-insured (complex because of ERISA)
    - Reintroduce health status as a rating factor (described in detail later)

Problem: young people in good health (and their employers) have few incentives to become insured

- There are good public policy reasons to assure that young healthy individuals become insured, even if they were not cross-subsidizing older or less healthy individuals
  - Avoids uncompensated care costs that are borne by all citizens
  - Improves access to affordable care, even with catastrophic policies
  - Develops the habit of being insured
- However, for the young, health insurance is a relatively low priority and even at rates that reflect true individual risk, is often not seen as a good deal
- Their employers face relatively high premiums because of the modified community rating and the broad array of required covered services
  - Young adults are often in low wage industries that find high premiums particularly problematic
- Possible actions:
  - Modify the community rating structure
  - Provide financial incentives to low income individuals
  - Require that individuals have catastrophic health insurance coverage
    - Premiums must be more affordable
    - People with serious illnesses and high health care costs must be protected financially
    - Federal and state support must be provided to low income individuals

Modifying the modified community rating

- Without introducing health status:
  - Increase the rating band to allow full adjustment for age (and geography) – roughly +- 55% instead of +- 40%
  - Add industry adjustments
- Adding health status to ratings (used in 41 states):
  - Add only behavioral risks – most notably smoking
  - Limit health status adjustment to a band much narrower than actual risk variation
  - Rather than a limit, use a blending of full risk rating and modified community rating (e.g., allow 50% of the risk to be reflected in the rate)
  - Move to full inclusion of health factors
- Issues
  - Minor adjustments are unlikely to correct the underlying problem
  - Adjustments large enough to address the problem require ways of addressing the high premiums of higher-risk groups and individuals

Reducing premiums through reinsurance or risk-transfer pools

- Mandatory participation by all carriers
- Pool assumes risk either automatically above an attachment point or through the health plan transferring the individual risk by paying a premium
- Individuals remain within the health plan they have chosen
- The key question: how is the pool funded?
  - Among health plans by assessing members
    - This may reduce premiums modestly because less “risk premium” needs to be included in the plan’s rate
    - As with so many things, the Maryland all-payer system offers a way to assess all payers (including ERISA plans)
  - Through outside funding
    - Premiums would be reduced more because of the infusion of outside funds
    - This is less a true savings than a transfer of costs
- Assignment or transfer to the pool could engage a separate health management program
- Reinsurance/risk transfer pools could attract new insurers

Establishing a separate high risk pool with active health management

- Like MHIP, but with more vigorous management
- Individuals would be insured under the HRP rather than the CSHBP
  - Possible problems because employer offers unequal benefits
  - Concerns about stigmatization
- Premiums would be substantially lower, approximating standard rates in the individual market
- Shortfalls in the HRP would have to be subsidized, just like reinsurance pools

Establish a state-wide purchasing pool

- Advantages:
  - Provide a **range of choices** to the employer - and to individual employees
  - Provide easy **portability** when unemployed or changing employers
  - Exercise **purchasing power** and influence benefit structures without using mandates
  - Provide **information** and publish plan comparisons
  - Efficiently **administer tax or voucher benefits** for eligible Marylanders
  - Options to manage risk selection through:
    - Risk adjusted payments to plans based on enrollees
    - Reinsurance pool

- Note that:
  - Choosing a purchasing pool approach does **not** determine the method used to set premiums.
  - Brokers will play crucial roles in marketing the plans and providing education
  - Having a purchasing pool does **not** in itself solve any of the risk selection problems discussed – it must be linked to other actions to assure a robust and representative pool
- Issues:
  - The legislature would need to insulate the plan from mandates
  - Who will operate the plan?

Timeline for Adopting Short Term Modifications to the CSHBP

Date	Action
September 2005	Staff presents a range of possible modifications to MHCC
October 2005	Town meetings are held throughout Maryland to receive public feedback
November 2005	Commission votes on modifications to the CSHBP
December 2005	Regulatory process begins
July 1, 2006	***Regulations are implemented***

Schedule of Town Meetings

Date	Location	Time
Wednesday, October 5, 2005	Cambridge Hyatt Regency Resort	9:00 a.m. – Noon
Wednesday, October 12, 2005	Hagerstown Clarion Hotel	11:00 a.m. – 2:00 p.m.
Thursday, October 20, 2005	Rockville Doubletree Hotel	11:00 a.m. – 2:00 p.m.
Wednesday, October 26, 2005`	Baltimore MHCC Offices	10:00 a.m. – 1:00 p.m.